COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

IN RE: EMERGENCY PREPAREDNESS & RESPONSE COMMITTEE MEETING

HEARD BEFORE: MARK DAY, CHAIR

EMERGENCY PREPAREDNESS & RESPONSE COMMITTEE

MAY 3, 2019

CONFERENCE CENTER

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND,VIRGINIA

8:03 A.M.

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APPEARANCES:

Mark Day, Presiding
Chair, Emergency Preparedness & Response Committee

EP&R COMMITTEE MEMBERS:

Patrick Ashley

Sam Bartle, MD

Ron Clinedinst

Michelle Cowling

Keith Dowler

Michael Feldman

Dan Gray

Robert Hawkins

Kelly Parker

VDH/OEMS STAFF:

Wanda Street

David P. Edwards

ALSO PRESENT:

Kelly Brown
Acute Care Crossover

James Giebfried
Post-Acute Care Crossover

Susan Union

Thomas Schwalenberg

ALSO PRESENT (con't.):

Ed Brazle

Nicole Laurin

Kelley Rumsey

Tanya Trevilian

A G E N D A

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Adjourn

(The Emergency Preparedness and Response Committee Meeting commenced at 8:03 a.m. A quorum was present and the Committee's agenda commenced as follows:)

MR. DAY: All right, good morning.

COMMITTEE MEMBER: Good morning.

MR. DAY: It's 8:03, so we're going to get started, Emergency Preparedness and Response group. And this is going to all be recorded.

COMMITTEE MEMBER: Both video and --

MR. DAY: No, it's audio recorded.

COMMITTEE MEMBER: That's good.

MR. DAY: So if you speak, please speak clearly and state your name for the recording. Because they don't -- they can't see who's speaking. So you have to state

your name. My name is Mark Day. And --

MS. PARKER: Kelly Parker.

MR. ASHLEY: Patrick Ashley.

MR. DOWLER: Keith Dowler.

MS. COWLING: Michelle Cowling.

MR. GRAY: Dan Gray.

MR. HAWKINS: Robert Hawkins.

MR. CLINEDINST: Ron Clinedinst.

MR. GIEBFRIED: Jim Giebfried.

MS. BROWN: Kelly Brown.

MS. STREET: Wanda Street.

MR. DAY: Okay. So we're going to get started. And even -- this is not like the TAG, so you guys, please, speak up in

the -- in the audience. You have your agenda there. And we're going to -- it's going to be a loose agenda because we came -- I came back from -- I had talked to Kelly the other day.

I came back from the trauma critical care, acute care surgery disaster meeting in Vegas and I have a couple of extra things. Because I have all of you guys in the room.

And it's hard to get you guys all in one place. So we have some things we want to talk about since the coalition's here. I can reach out to Michelle. So -- so she's my region. And Kelly.

So this morning, we -- and we didn't -- we're in the -- did you guys -- did you guys get the -- the meeting minutes? Does anybody have any -- any --

COMMITTEE MEMBER: Transcript.

MR. DAY: You have a transcripted -- that looks like a court transcription, didn't it? I was like, ooh.

MS. STREET: It -- it's done by a Court Reporter.

MR. DAY: Yeah -- oh, so it was.

MS. STREET: Mm-hmm.

MR. DAY: That's why it looked like that.

MS. STREET: Yeah.

MR. DAY: Does anybody have any -- anything to add?

MS. PARKER: Erin, who's not here, did -- does have a list of edits, just corrections for acronyms and just some verbiage changes. Nothing substantial in terms of content. But just corrections.

MR. DAY: Okay. So we -- can we get that, right?

MS. STREET: Mm-hmm.

MR. DAY: Okay. We'll send it to Wanda. All right. So like I said, the agenda's going to change. So hang in there. I do want to open up with a little bit of some of the things that happened over the last couple of months.

We have -- and this is not just the State, but we want to talk a little bit about what we had down in our region. We had a little bit of a pediatric mass casualty drill down in our area.

And I didn't want to let that out early because I didn't want a bunch of people down there with signs protesting. We all know how that happens. So it -- it happened at a school.

We did a school mass -- mass casual -- mass shooting drill. And we had run by the EMS, fire and the police department.

So it went kind of the way you would've thought it went with the police department entering the school. Can I use this? I can't. The school was out in Pungo. And the problem was that the school

had entrances like this. So when you think about how you would gather your patients, how do you think that that went? Just like you would think, right?

So the PD went in and the PD did like all -- most PD -- even though they trained really well together. I think they did a really good job. They did train very well together, PD and fire and EMS.

And it did take them a little bit of extra time to get the first patient seen by EMS. Which has been right along with how things have been going.

It takes a little bit more than just one drill to get PD to do -- to really play well with EMS and fire. You can't expect that in one drill. What happened was they started bringing patients here, here, here and here.

So it was kind of -- so like I said, one drill does not make great team work, but it's a work in progress. It's a work in progress. Not it. Wasn't me. Like Loretta and I when we teach, it's not me. It's not my phone. So there's a lot of work

to do. And the -- one of the really great things is we've done a lot of training between Virginia Beach EMS, the hospitals and Virginia Beach Police Department.

So there's a great camaraderie there. And this is only going to go in the right direction. So -- but with -- when it comes to kids and it comes to schools, you really -- you really want to get this right.

So -- questions on that? Questions -- does anybody have any questions? Anyone have any -- any other drills that anybody was part of? Chief, do you have anything that had -- chief --

COMMITTEE MEMBER: No. No, I still don't want to waste the work product. Last time we did it, it took over 45 minutes before --

MR. DAY: Right.

COMMITTEE MEMBER: -- we could get rolling. So we were --

MR. DAY: Well, we were going in the right direction, we really were.

COMMITTEE MEMBER: They'll straighten it. The police are all about moving --

MR. DAY: Yeah.

COMMITTEE MEMBER: -- moving bodies. I can just tell you we had a little problem.

MR. DAY: You walk in right then and talking -- we're talking about that pediatric -- so we are going in the right direction.

It's just -- it's going to be a -- a lot of work in progress. And it's far better than our Sandbridge pediatric debacle that -- that happened.

So how is -- is anybody else doing straight pediatric mass casualty drills in the region -- in your regions? I recommend that that be something -- because

this is -- listen to this, you here?

MS. COWLING: We -- yes. All of our coalitions have to create a pediatric surge annex this upcoming budget period, which would be -- begins July 1 to June 30, 2020.

So that's something that we just talked about this week amongst our team. Determining how that's going to look in the regions and then determining how to coordinate across six regions.

Because likely a large pediatric disaster is going to span out beyond just one general area.

MR. DOWLER: Keith Dowler with Northern Virginia Hospital Alliance. I follow instructions. Yes, we -- we've table topped it.

We're table topped a regional pediatric MCI in the last year, 18 months. And just looking at the allocation issues that we face, the surge not only capacity but capabilities of emergency departments

that say on a normal basis they don't treat kids. But they do today in a type of MCI. It was particularly interesting.

The tactical piece for on-scene MCI and how that translates to appropriate patient allocation is definitely something we want to learn more about.

And I think the only way we can do that is probably going beyond table top exercises. But I would definitely advocate, at least at the beginning, for a phased approach towards a more full scale type exercise.

MR. DAY: And this was on a weekend, not during school time. And I think if you don't -- you don't get into either using a youth center, a school -- you know, an elementary school -- because high schools are not kids.

High schools are adults. You know, using an elementary school and -- you got to keep it quiet because like we talked about. If you don't -- if you don't keep it quiet, you're going to have the -- all the

crazies out there coming to -- with their picket signs -- and the anti-guns. If you want a good -- and they -- Beach EMS, they -- and the fire, they did a great job keeping that quiet.

And was it -- were able to run a really good drill. And they -- but they had to do it out in Pungo where, you know, it's away from everybody. So that you don't have a lot of lookies [sp] when they're setting it up.

But to be able to get -- and you got to get good actors. You got to get these kids in there to -- to actually have real live kids to do this thing. And it -- I think it was really -- a would've run -- run -- really well run -- yes, sir.

MR. GIEBFRIED: I just had a question, and a follow up on this drill. You said you had actors. But what about family members who respond once they hear that a disaster's occurred.

MR. DAY: That wasn't part of this

group. That wasn't -- that wasn't part of this group. That wasn't built in. That wasn't where they were looking -- looking at for this.

MR. GIEBFRIED: And one follow up on that. The movement of the number of individuals from the facility who -- areas to be cared for. Was it considered to use just the ambulances, or was it considered the possibility of having to move by bus?

MR. DAY: We didn't -- we didn't move casualties this time. But we have -- in our region, we have the ability to move ambulances, ambulance buses. We have at least one helicopter we could've called in.

The multiple -- we have their county, we have life -- helicopter from up in -- by Riverside. We -- just because of -- a bus.

Like I said, the hospital has one. Virginia Beach EMS has one. Chesapeake has one. We have assets to move the children.

COMMITTEE MEMBER: Do y'all have an after action report --

MR. DAY: We will.

COMMITTEE MEMBER: -- of what you do?

MR. DAY: And we will have one to bring.

DR. BARTLE: I think one thing that someone made clear on trying to figure out, you know, pediatric disaster plan. What exactly is our pediatric capability?

MR. DAY: And that's true. This was more for the -- more for PD and fire and EMS at that -- that point. We hadn't moved it up to -- because what I still wanted to do in -- CHK's not here.

It's really hard and -- and I'm really -- I got to get Ann Kuhn to really get that involved. And -- because this is where -- and this is going to go

into the next part of what I want to talk about, is the pediatric care part. You know, CHKD is now a trauma center. But you look at it, it's not VCU's pediatric trauma center.

It's not Northern Virginia's pediatric trauma center. It's not Carilion's pediatric trauma center. It's still --

MS. BROWN: One clarification. Northern Virginia doesn't have a pediatric trauma center.

MR. DAY: Oh, it doesn't?

MS. BROWN: No.

COMMITTEE MEMBER: No.

MR. DAY: Oh. Well, no, it goes into Washington, right, DC.

MS. BROWN: DC, Children's National.

MR. DAY: Children's National. So CHKD is still pretty small when it comes to -- and their brand new at pediatric trauma. So we would still be looking at a lot of help from the adult -- true adult trauma centers trying to take care of those pediatric care -- those pediatric kids. So and then we would be looking at moving out of the region. Yes, ma'am.

COMMITTEE MEMBER: Okay, sorry, Mark. Where did you get your volunteers from? Did you use a Boy Scout troop, did you use staff?

COMMITTEE MEMBER: I -- I wasn't --

MR. DAY: I -- I think it was -- in my -- what is that? Medical --

COMMITTEE MEMBER: MRC.

MR. DAY: Yes, MRC.

COMMITTEE MEMBER: MRC?

MR. DAY: Yeah. It was MRC.

COMMITTEE MEMBER: So kind of going back to -- to Dr. Bartle's comment. And looking at maybe not specifically the individual exercises that go on, but starting to look statewide as to what our capabilities are.

Dan, I don't know if you would be able to touch at all on just a little bit of the work that you've done in pediatrics, in terms of that assessment. If you got a pretty good picture of what the capabilities are in your regions.

And then any of the other folks in your regions, if you have that knowledge now or where would we kind of start with that type of an assessment.

MR. GRAY: Yeah. I mean, we did the assessment. And then, you know, kind of the peds thing bubbled up, that's something that we wanted to work on. And so we -- we looked at those assessments and then -- and then -- just the numbers that came, I kind

of knew that we weren't that good.

COMMITTEE MEMBER: And who -- who did those assessments?

MR. GRAY: This was the -- he was here the first meeting. David Edwards.

COMMITTEE MEMBER: EMSC.

MR. GRAY: Yes.

MR. DOWLER: Peds readiness?

MR. GRAY: Pardon me?

MR. DOWLER: Peds readiness.

MR. GRAY: Right, right. So what we found out in our region, something that -- contributing factors to the overall grade, per se, from each of facility is some of the questions were a little tricky. And -- and the actual facility was answering them incorrectly. They were reading the

questions incorrectly. So that's what they all worked with David with in trying to -- what -- what is the answer you're really trying to get out of this question.

Because once we learn that, then we re-did the assessment. Then the hospitals and the folks that took the assessment were like, oh. Okay.

COMMITTEE MEMBER: What was the confusion?

MR. GRAY: I don't -- it's been two years ago. And then my long term care coordinator, that -- she's the one that really had handled that assessment.

So I don't want to even try to answer that question for you without having something to look. I'm sorry.

COMMITTEE MEMBER: I'm just curious because for National EMSC program had all these questions and the -- the survey. So if it's something that's confusing, they need to know --

MR. GRAY: Right.

COMMITTEE MEMBER: -- to roll it out.

MR. GRAY: I think David had pushed that up because, you know, we -- we pointed out the issues they had answering the questions. So when we re-did the assessment, our numbers went down -- which was expected.

I expected that because I -- when I saw those initial numbers, I was like -- and we're not that good at pediatrics in rural southwest Virginia.

We're just not. So with that stand to is, what kind of supplies, what kind of inventory did we have at each facility.

And how do we kind of -- and we're still working on that because a lot of facilities are a lot different across the board in -- from one side of my region to the other. But we're trying to standardize it, at least a certain par level of

pediatric supplies in the facility. And then we're trying to do education with pediatrics as well to help up -- up the capabilities of treating the peds, you know, in the event of a disaster.

So I admit it's an ongoing project. But it's been a good project. It's been very eye-opening, not only to me, but to the coalition group in each hospital as well.

And I can -- you know, I can pull up some more information for the next meeting or whatever you guys want me to do for that. For more -- more details of what we've done.

COMMITTEE MEMBER: Are you going to use those assessment results to help with your pediatric surge annex?

MR. GRAY: Absolutely. Absolutely. I -- I just made a note as we were talking. I want to get back there and revisit those things and get the dust off of them, and digest that again.

MR. DAY: Because one of the things -- oh, yes, sir.

MR. GIEBFRIED: I just had one for [unintelligible].

MR. DAY: Yeah.

MR. GIEBFRIED: When you said equipment and finding whether or not you had the right pediatric equipment on your ambulances to respond, what have you done to change that as far as adding to your supply, or when you get the call, you know you -- you're grabbing certain equipment before you're going out? And how does that effect your time to respond?

MR. GRAY: Well just simplistic, a couple of things that we found. We had a couple of hospitals where they were having issues with -- from pounds to kilograms. There was a big issue there. And they couldn't measure, I guess, in kilograms is where you really -- yeah. So that was huge.

I mean, something that simple was huge.

MR. DAY: One of the things --

COMMITTEE MEMBER: We've got a lot [unintelligible].

MR. DAY: Yeah. If this is a -- if this is a push this year, if the coalitions have money for training, we can push the EMP-C course for the ER's, even non -- non-trauma centers, but the ER's period. What do you think, Kelly?

MS. RUMSEY: It's -- it's a tough year for EMP-C.

MR. DAY: I know because you just changed.

MS. RUMSEY: And I'm the only course director at my facility.

MR. DAY: I mean, we've got two courses this year in Hampton Roads. I don't

know what Lou Ann's got.

COMMITTEE MEMBER: Like we could do [unintelligible], we can get in contact with about --

MR. DAY: Because that's going --

(At this time, several committee members began talking at once.)

MR. DAY: -- pediatrics course.

COMMITTEE MEMBER: I have not --

MS. PARKER: I don't know anything, to be honest, about the course.

COMMITTEE MEMBER: Okay.

MS. PARKER: But the coalitions have a pretty structured budget process where their coalition -- their -- their projects need to be identified based off of their HVA's, based off their strategic plan.

And if it's a need that's identified in the coalition, then the members of the coalition -- who are the hospitals and -- will identify that need.

And it'll be put into the budget. So we don't really direct where their funding goes unless if it is a strategic priority --

COMMITTEE MEMBER: How long does that take?

MS. PARKER: -- put down benefits.

COMMITTEE MEMBER: How long does that --

MR. DAY: Should've been already done.

MS. PARKER: It's currently in for next year, so we're almost finished with the budget process for -- for the next year. Now that doesn't -- that doesn't mean to say -- I mean, you guys speak up here. Because

it's your -- they're your budgets. I didn't mean to say we can't do it, but --

COMMITTEE MEMBER: Was the focus on hospital side education or EMS?

COMMITTEE MEMBER: Right.

MR. DAY: Yes. Yes.

MS. RUMSEY: So I mean, there's also the EPC course for that.

MR. DAY: Yep, for pre-hospital.

MS. RUMSEY: Pre-hospital, the EM -- and AEMT course. So --

MR. DAY: Right.

MS. RUMSEY: They are both -- they're both --

MR. DOWLER: They're bumped.

MS. RUMSEY: I don't know, does anybody teach -- is it PEP or are there other variations on that?

MR. DOWLER: No. PEP was in place when EPC --

MS. RUMSEY: Okay. Totally deleted? Okay.

MR. DOWLER: I'm curious -- I'm curious to know, the assessment is interesting to me in particular. Aside from stuff staffs face, the usual MCI questions that we ask when we're trying to figure out what our surge capability asset is.

What else would that -- what else would that assessment look like? And how could we standardize it in a way that we could get meaningful results from across the entire state, maybe by region, based on what's around a trauma center. But I think it's important to note, as the lady had mentioned back -- in the back mentioned, rather, Inova Fairfax Hospital, we are an

adult trauma and pediatric center. We're not a pediatric trauma hospital. But that doesn't mean we don't do pediatric trauma almost every day.

MR. DAY: Yeah.

MR. DOWLER: So how do we strip away, to some degree, the ACS designations, the VDH designations and just look at what can you actually do today.

MR. DAY: That's what the peds readiness --

MS. RUMSEY: Correct.

MR. DAY: -- starts to look at. And I think this -- that's a beginning level. And it comes up like someone -- where what has been done, once the facility has learned what they -- where they rank in all this. Dave, can you give us a -- give a brief summary on what the peds readiness survey looked at.

MR. EDWARDS: When it's coming to me or --

MR. DAY: Well, what is already known that -- I think it's a new process that --

MR. EDWARDS: Oh. The last version -- they tried to stay the same. And a part of what they -- they ask emergency departments is whether they have a specific pediatric component to -- in their disaster plans. And whether they exercise it or not. And -- and Dan would -- would remember that.

MR. GRAY: Yeah. And now you -- you're here now, thank goodness. They were asking me some questions. I was like, where's David?

I think why now I remember one of the big components, too, was to have what they called a pediatric champion at your facility --

MR. EDWARDS: Right.

MR. GRAY: -- that stayed on top of the supplies and the continuing education and checking all the boxes.

MR. EDWARDS: And they consider that to be one of the -- one of the most important things.

MR. GRAY: Right.

MR. EDWARDS: To have a -- both a physician and a nurse in that role at the hospital. And actually, I -- I can tell you now that they're doing the next pediatric readiness assessment.

It's going to begin June 20th. I mean, June in 2020 for four months. So -- and we're going to try to get everyone to complete one of those to get a more complete picture --

MR. GRAY: 2020, right? Is that what you said, 2020?

MR. EDWARDS: Yeah.

COMMITTEE MEMBER: Correct.

COMMITTEE MEMBER: Correct.

MR. EDWARDS: Can you -- to sort of answer your question. It's not to -- it's more geared towards the hospitals aren't seeing a lot of kids. You know, not your big -- your medical centers like Inova or UVa.

These are the smaller community or very -- just turned that -- rural or less busier ER's. Because that's where the ideas that the concerns that some of the things are missed. So...

COMMITTEE MEMBER: That makes sense.

MR. DAY: Yeah. I'm not as worried about the trauma centers, because that's built -- peds is built into the trauma centers. It's their rural or your non-designated service that -- that you worry about.

MR. DOWLER: I think the -- the concern with all this is that you have all the -- the finance accent involving pediatrics or a large number of pediatric patients.

That number's going to be much less than the number of adults that will overwhelm your resources. And at what point do they go from the more community level hospital into the medical center, and how do you do it.

So somewhere out in a rural area, they may go to Inova, being transported up there. And at what point do you do that, how do you do it? Is some of -- resources are not always there.

And if you have five kids, does that community [unintelligible]. So if someone come to your ER directly, it's not that. It's that you're the next level.

MR. DAY: Right.

MR. DOWLER: And depending on what's going on, you -- I don't know what

your criteria is going to the next level, throw the peds to Children's. But that's what this is trying to look at. It's get -- is this -- it needs to be beds and state.

MR. DAY: It got to be what? 20? 30? So -- and those will be filled. Probably the big -- of course, it's going to be filled already. So --

COMMITTEE MEMBER: If it's four --

MR. DAY: Before we even get started.

MR. DOWLER: So it's really looking at that tolerance by community for acute -- acute pediatric. That makes sense. And -- and I think it would be pretty interesting to see how that would cascade -- not just in Virginia, but --

MR. DAY: There was a -- someone did a -- describe a scenario, if it happened a day -- not -- a trauma level where

everyone gets hurt. You know, some big school area that bombed -- got hit with something. What happens if these kids have to go out of state?

COMMITTEE MEMBER: Because how many pediatric medical center are in -- you know, some states don't even have them. So how do you -- how do you correlate that?

MR. DOWLER: So -- so there is an explosion and likely to have a fair number of burn injuries with that. We have -- in the southern region, we're a part of the southern region burn area and we -- there's a number -- and this is in our mass casualty plan that we can call and activate every burn center from Texas to Virginia.

And then, they gather information about how many beds they have, how many can take pediatric patients. And you go from there.

COMMITTEE MEMBER: Well, burns -- that's good, as far as your typical peds

trauma.

MR. DOWLER: Sure. But if it's an explosion, it's -- that's something --

COMMITTEE MEMBER: Burn and trauma.

MR. DOWLER: -- the burn center would need to be involved in.

COMMITTEE MEMBER: Yeah.

MR. DOWLER: And that -- and that's -- I mean, that would be one answer to that complicated question. So I -- I can get that information and we can distribute it. Because there's one number to call that can activate the southern region.

MR. DAY: Yeah. Because even in Hampton Roads, we're looking at -- we're looking at going VCU and then south into the -- the triangle, down to the -- Duke, Wake, all that down there.

MR. DOWLER: Right. And I think that's just as interesting --

MR. DAY: That's out of state.

MR. DOWLER: -- as knowing numbers and what your capacities are. Know what flow patterns already exist.

MR. DAY: Yeah.

COMMITTEE MEMBER: That's one --

MR. EDWARDS: And in fact, that might be probably the lowest hanging fruit. Just ask, where do you send referrals? Where -- where do you send -- where -- where do you send highest acuity cases which you can't handle.

COMMITTEE MEMBER: Our first call is to VCU to say we're calling right now. We're trying to --

MR. DOWLER: And to do that by

facility, that could be powerful, Dave.

MR. EDWARDS: Oh, it -- yeah. Yeah.

COMMITTEE MEMBER: We -- I'm sure you guys have this as well. But we have memorandums that --

MR. DAY: Yes.

COMMITTEE MEMBER: Understanding. There's collaboration, up north as well. So I think a hospital center and -- they have the children's hospital near -- near them. And then north of them is Hawkins. And some other options as well.

MS. COWLING: It just recently -- Michelle Cowling -- eastern. And I work close with Mark. CHKD just this past or this current budget period did have an emergency preparedness and response training, intrinsically that they held at EVMS. And they're actually getting ready to

post a trauma conference. So this was the first year. So the funding from the coalition is starting to flow in -- into them.

And they're going to repeat again next year because they had such a good response or attendance, very high attendance. And we are actually working with them now to plan that coming exercise.

But again, like Keith was saying, that phased approach starting -- we got to start somewhere.

MR. DOWLER: Yeah.

MS. COWLING: It can domino.

MR. DAY: Yes, ma'am.

MS. COWLING: Just to the -- expect education again. Another option is the rural trauma team development course. It has a small pediatric component. But the whole kind of concept around RTCDC is that the trauma center takes it out to the

non-trauma center and customizes it, to some extent, to meet the needs of that facility. So it is very much intended to meet the -- the rural or the critical access referral hospitals' needs. And I know there are several trauma centers across the state that offer RTCDC.

MR. DAY: So that kind of builds in -- I want to talk about the -- the moving up, well, into the pediatric critical care. And we talked about this a little bit last time, moving into the ability to -- if you want to say face-timing -- pediatric critical care for the first 24 hours to these -- these smaller facilities.

Ours being one of those. And I had talked to -- I'm going to use our facility as a -- as a point of contact here. I talked to our critical care team because one of the things we've been very happy with is to move our kids over to CHKD. Been very happy that they've been -- now a trauma center. But if Hampton Roads has a problem, CHKD is not going to be able to hold all

these kids. We're going to be back to holding kids again. And our critical care team's like, oh, my God. What are we going to do?

So when I said we had talked about the possibility of face-timing with pediatric intensivists, they're like, oh, my God. That would be fantastic.

How do we set this up across the state -- in the state, being so we're not crossing state lines. How can we do this to set up in case something happens where our intensive care now has half of -- half of the ICU with pediatric trauma patients under the age of 12.

And they're having to hold for maybe 24-48 hours until we can move them out to another -- to a pediatric trauma center. And they can have a pediatric intensive care or a pediatric trauma intensivist assistance to care for these patients.

MR. DOWLER: Mark, I don't know if it's a place to start, but it might be worthwhile to have a presentation from the

Northern Virginia EICU, which is a part of the Inova Health System, but services the entire region, as the focal point for telemedicine carts, which are placed in all of your emergency departments for the 17 hospitals in Northern Virginia.

With the push of a button, a -- the -- our EICU will -- will come on line. It'll be a voice and audio experience. And they can easily patch it through to wherever the specialist is that we need to get a hold of.

And most often, it -- it goes to one of the trauma centers. On -- in a disaster situation, a physician called a regional triage officer position is activated where one of the ED physicians can provide consult to anybody who needs an extra set of eyes at any of the other hospitals.

That whole concept was presented, in fact, last week to the Wall Street Journal down in DC from our director in that department as a capability that we should be looking at in the same way you

just described, as a statewide thing, as a national thing. Why can't we activate these resources? But my question in all of this is, what are the limitations to that?

How much value does that actually bring? And maybe it does bring a lot to more rural hospitals. Maybe it's more of a barrier.

Maybe it's just another thing that's going to collect dust. I don't know. I'm -- I'm interested in the thought.

COMMITTEE MEMBER: It's good no one's asking the easy questions here. There's -- so -- so we need systems that talk to each other.

And we need people who understand compliance and privileging and -- and how hospitals that aren't in the same system can have practitioners talking to each other.

So it -- it might be worthwhile having someone here who is more learned on -- on that compliance part of it. And then having talked about this a lot, the

burn community. There's so many different systems and there's cost with each and their different apps. And not everything talks to everything else.

So you -- you've got a great system it sounds like. But should we adopt that? Does everyone adopt it? I don't know. So I think we need more information on that.

MR. DAY: Just use face time.

COMMITTEE MEMBER: Well, that's what I said. Well, Dr. Greenburg said -- he goes, I can dial them up on my phone.

MR. DOWLER: Face time is not up to compliant.

COMMITTEE MEMBER: It's not HIPPA compliant. Right.

MR. DOWLER: You can't -- you can't do that.

COMMITTEE MEMBER: You can't use a Google doc.

MS. PARKER: You could.

COMMITTEE MEMBER: I think it would open you up to other issues. And that's why I think we need compliance, somebody who -- who knows more about that intrinsic issue.

MR. DAY: But he -- he said, you know, I'm more than happy to do this. But I need a -- I would want to have access to a pediatric trauma critical care position --

COMMITTEE MEMBER: Sure.

MR. DAY: -- at some point. Because something's going to come up that I have to -- I need to ask somebody. I need some -- what is it -- I need to phone a friend.

COMMITTEE MEMBER: Yeah.

MR. EDWARDS: They're going to need a way to document it all --

MR. DAY: Right.

MR. EDWARDS: -- as well.

MR. DAY: Right.

COMMITTEE MEMBER: Because now we get people will call the center. And this is what I have. What do you think I need to do? And it's -- I'm not sure how other places document.

We have a brief note to put into the computer. And that's -- if they come, that's great. If they don't, I'm not sure what -- what happens to it. You know, that's -- that's part of, I think, what he's saying.

MR. DAY: Because burn would be the same thing. If we had a massive burn thing, they're not all going to get out of a -- a facility in the first 24, maybe 48 hours.

They might need the same thing, a trauma surgeon might need the same thing with a burn physician.

COMMITTEE MEMBER: Right.

MR. DAY: Hey. This is what I got. Am I doing the right thing, or do you think I need to do something else?

COMMITTEE MEMBER: You put a camera on the wound and you can talk about things. And that's what we want to do in the future. But we have -- we have to build that system.

MR. DAY: Right.

COMMITTEE MEMBER: We just started that conversation couple weeks ago.

MR. DAY: Yes, ma'am.

COMMITTEE MEMBER: One of the biggest thing we really want to do -- I think is the biggest thing, the -- the

equipment and having that on hand. Especially when you're -- we've had damage control time. Especially for pediatrics.

What is the equipment I need to have on hand that's pediatric sized to get through this damage control period that -- what is it? That -- you know, kind of damage control.

You know, I always have the adults. That's what I have for a lot of -- so to do my damage control. If you only really have had damage control period of time, that window.

Because I can eventually get them to an ICU. Right? Because I can find an ICU eventually doing -- some are right in the middle of equipment anywhere, right? Even Afghanistan, I can get them from somewhere eventually, right?

Falling in eventually. But I'm doing damage control and we'll network. I need pediatric. When we were in Afghanistan, I got -- I was able to do -- I had -- I go -- I knew I had adults, but I was getting kids occasionally. I'm like, oh

crap, how much -- a little bitty things that I need to have on hand. But if we got peds, we were like, Holy crap.

So we -- even in here, we got to figure out what is the total damage -- for -- how much volume of pediatric things do I need to have on hand?

That's what we need to figure out for the -- for the State of Virginia. What is my surge for an emergency when that bus rolled over full of kids.

I need to have my hand on my facility to care for the -- the victims. So trauma -- but damage control window, if I can get it to CHKD or wherever to manage it. They need smaller whatever.

But we can't put anything on a pediatric patient. I can't do that. I need to have the smaller level of things. So what if I surge and get to that?

That's -- I think that's the bigger question. Because I can eventually get them to a hospital somewhere else, send them to maybe another state or somewhere like that. That you can eventually get

into. But what about you taking care of them in the mean -- the meantime.

MR. EDWARDS: That's sort of what we -- Gray needs to bring this --

MR. GRAY: Right.

MR. EDWARDS: -- assessments for y'all to look at. And then -- and some places are better. They're more interested in doing it.

But they have to keep that interest up. Because if they don't use it and then they look at and go, why are we doing it.

But you have to understand, this is something that's not -- it's like any other equipment. You may not use it frequently, but you have to have it.

COMMITTEE MEMBER: So we have these cachets in equipment spread around the state. Does that have pediatric equipment in it?

COMMITTEE MEMBER: The stockpile?

MR. EDWARDS: The -- the burn cache.

COMMITTEE MEMBER: No. It just has --

MR. EDWARDS: Wound care.

COMMITTEE MEMBER: Yeah, I don't think it's anything pediatrics specifically.

COMMITTEE MEMBER: I want to call it correctly.

MS. STREET: Can y'all speak up?

MS. PARKER: We couldn't hear.

COMMITTEE MEMBER: Oh. The burn kits that are in the regional cache, I don't think there's anything pediatric specific in there.

MR. EDWARDS: Not specific.

MS. PARKER: Okay.

COMMITTEE MEMBER: I mean, even the critical care kits, I think, is adult, like a 7.0 ET tube and a full size Ambu bag.

COMMITTEE MEMBER: So should we add that to those caches?

COMMITTEE MEMBER: Well at one point in time, there were multiple Broselow kits in the region -- at least in central Virginia. However, they all expired and there was no flow to replace them.

So I think it has been done once before. But I'm not sure how it's been maintained.

COMMITTEE MEMBER: Okay.

MR. GRAY: That's one of the things we looked at after our assessment. We're talking about getting all the hospitals that

are rural. You know, there's needles that would expire because no one used them. We got a pretty big health system now. And to -- I mean, go for size.

But at any rate, we're looking across the board at the supply chain management, too, how -- how could we effectively use these larger health systems to help mitigate some of the higher costs of those things -- exactly what you said. We don't use them, but you need them.

COMMITTEE MEMBER: Yeah.

MR. GRAY: And it's not, you know, it's not if you buy the stuff that you have to buy it. And how can you do that more cost effectively and the day we know we're going to have to throw them out, which is bad.

COMMITTEE MEMBER: But can -- could you be able to maintain them --

MR. GRAY: Right, yeah.

COMMITTEE MEMBER: -- with the cost of those salves and creams is outstanding.

MR. GRAY: Right.

MR. DOWLER: I think that's an important point. And we've seen it time and time again. And it was mentioned that caches expire.

And although we -- we hope they don't and we may put in some plan for how they won't, maybe -- I don't know what that answer is. I know it in -- in my space, we try to just up the par level.

And that naturally adds a little bit. And although the par level doesn't necessarily reflect our volume for the stuff that we use, just a 10% increase on par is going to make a big difference.

I'm not -- and then -- and then the other -- the issue with caches is unless you're putting them in every single emergency department, it's going to take hours to get there. And by then, you're out of damage control. I just -- the cache

piece concerns me as I've seen far too many millions of dollar go -- go to waste because it's not rotated and not taken care of.

MR. DAY: Mm-hmm.

COMMITTEE MEMBER: The point-counterpoint is we already have it. And it's already in the system where it's being replenished.

So it might be worthwhile to get more information about it before we make a decision where -- where are they, what is in each cache and we --

COMMITTEE MEMBER: How's it rotated.

COMMITTEE MEMBER: -- we could go from there. Yeah. I think that's an important piece. Just -- just with the patient flow, how are the resources managed for the resources you do have that can address pediatrics, too.

COMMITTEE MEMBER: It'd be kind of nice if there's knowing something's happening, we can forward what you need to that place. Sort of like FedEx.

(At this time, several committee members began talking all at once.

COMMITTEE MEMBER: But I mean, that's -- that's --

COMMITTEE MEMBER: Best of any concept. We could.

MR. DAY: Yeah.

COMMITTEE MEMBER: Explore your contracts with Amazon Prime. Now one-hour delivery for some gauze. I mean --

COMMITTEE MEMBER: And that's good.

MR. ASHLEY: And we see hospitals all -- this is Patrick Ashley. But we see hospitals all the time courier things back

and forth, whether it's medication or a thing of CroFab, you know, the -- you know, that happens all the time when somebody doesn't have enough. It's -- things are moving all the time. So we just need to tap into those.

COMMITTEE MEMBER: Can it get there quick enough for the damage control?

COMMITTEE MEMBER: Well, we have the -- yeah, we ought to be -- we ought to have the ability -- not having the ability to transport a patient anywhere. Is that what you --

MR. DAY: Well, it's stuff.

COMMITTEE MEMBER: Huh?

MR. DAY: Stuff.

COMMITTEE MEMBER: Things.

MR. DAY: Initial -- initial care

--

COMMITTEE MEMBER: Some patients been transported immediately. Some of them need to be stabilized.

COMMITTEE MEMBER: No, I get that -- no, I got that part.

COMMITTEE MEMBER: Yeah. But the question is, you know, once you decide who that's going to be, the ones that's staying behind -- the less critical ones.

MS. PARKER: So for -- for purposes of this group, and also kind of for our health care coalitions because there's -- there's certain objectives that I think we are supposed to meet here.

We have coalitions who are supposed to meet certain objectives, and so I kind of want to maybe talk about how we can help each other meet those objectives. Some of the objectives of this group are to help inform state plans --

COMMITTEE MEMBER: Right.

MS. PARKER: -- which is exactly what the coalitions are working on in this next year for pediatrics. And that would -- that would roll up to the State. I mean, we've heard a lot about assessments.

We've heard a lot about the planning, you know, kind of doing a baseline study of where our capabilities are at. Kind of doing a baseline study of where the normal transfer of pediatric patients goes.

We've talked a lot about training exercises and then stuff. Where -- where do we start from this perspective? Like what can this group inform the State on, or what should we work on?

COMMITTEE MEMBER: The right questions. Because it's easy to ask questions. I think it's hard to ask the right questions and looking -- the deference to some expertise on the medical and clinical side from our nursing and physician partners, I think, would go a long way to

building a meaningful assessment. Sorry, was that --

MS. PARKER: No.

COMMITTEE MEMBER: I would say a lot of this work has been done, especially with the EMS-C peds ready, the capabilities have been assessed. There's a document from EMS-C, the hospital readiness checklist.

And I think that was, for us, where we started. It's -- it's a GAP analysis. But every hospital has to look at what's -- what they have individually.

So is there a way to work with your hospital partners to push that out and say, we really -- you really need to look at what works for you. Because what works at VCU isn't going to work in rural southwest Virginia.

MR. DAY: Right.

COMMITTEE MEMBER: And -- and conduct that internal GAP analysis between

stuff and people and spaces. And then come up with what their needs are. And I think that's where the coalitions help to fill those gaps, if the hospital can't fill them individually.

COMMITTEE MEMBER: I think that'd be us to --

COMMITTEE MEMBER: Does anybody else work with that document? You don't count.

MR. EDWARDS: I've been told that.

MR. DAY: And if nothing else, encourage the hospitals in your area, you know, what needs to be done. And we have a good -- what is it, like 98-97% return?

COMMITTEE MEMBER: For the -- for the last time for participation?

MR. DAY: Yeah.

COMMITTEE MEMBER: 100% of civilian hospitals.

MR. DAY: Okay.

COMMITTEE MEMBER: I'm thinking Dave.

MR. GRAY: I think one of the big things with the assessment as well and one of the things we looked at that's free is the annual awareness of pediatrics.

MR. DAY: Yes.

MR. GRAY: Just -- just the simple fact that someone goes in there and opens the Broselow cart and counts the pieces and the parts and pays attention. And it's -- you know what I mean -- it's just fresh on your mind every year.

I think that's huge and that's free. I mean, that's -- you know, it's kind of like education is what kind of way I look at it.

MR. DAY: That's -- well --

MR. GRAY: I mean, obviously we need to go up and beyond of that. But I mean, that's -- that's --

COMMITTEE MEMBER: -- champion is supposed to be doing this.

MR. GRAY: Yes. Yeah.

COMMITTEE MEMBER: That'll be a huge step forward is if each hospital would designate a pediatric champion.

MR. GRAY: And that was one of our huge problems that we had that no one checked that box. I'm like, well, Kelly does it. Well, I know that Robert does it. That's what it was.

COMMITTEE MEMBER: Where did you end up? Did you get most of them to do that?

MR. GRAY: Yes. I don't think we got them all that failed yet. I know we have issues in our region with --

COMMITTEE MEMBER: Sure.

MR. GRAY: -- contracted staff and -- they move around and they were there, and now they're gone. It's just -- just a revolving door, you know.

But I mean, it's something we -- it obviously was a gap we identified. And it's something that we're working towards, so if we can get there and we put the --

MS. PARKER: Ryan, Robert, you guys have any thoughts on -- on where you're going to start for your pediatric surge plans? Or -- I don't know if you thought that far out yet. I mean, that's a new --

COMMITTEE MEMBER: Not completely, other than the fact that we are reaching out to the Pediatric National Coalition. We

actually have one of our staff members that's a member of that. We're actually going to talk to them and find out what is the best practice that's been developed by the coalition and work from there.

When we do our surge plan that we're going to look at for next year -- that we're budgeting for -- that's part of it that's included.

And then in November, we're actually bringing back the pediatric disaster training course that's offered by TEEX. We're bringing it back for a second time.

MR. HAWKINS: Similar to that -- this is Robert Hawkins from near southwest. We're going to look at the pediatrics and disaster course at at a minimum. That seems to be the most readily accessible training course.

But there are others out there, so we're going to have to explore some of those options. And with the new requirement of having a physician or a

clinical consultant to our coalitions, our operational strategy at this point is to create a physician work group that's going to be able to give us that subject matter expertise based on different disciplines to advise our coalition which direction to go.

And I'm even open to exploring -- it's something I may speak of fondly is actually doing a pediatric disaster work group to start informing us as to how we need to write our -- our regional plans for this next fiscal period.

MS. PARKER: I can't think of where to go from here. So you know, I don't know if we start with those basic assessments we -- do you -- do you guys have all those in the regions? I know the -- the EMS-C result?

COMMITTEE MEMBER: I'm sorry.

MS. PARKER: I was asking the folks in the coalitions if you guys have the EMS-C results from the last survey that was done.

I know, Dan, you do. But --

MR. GRAY: Yeah, I do.

MS. PARKER: Okay.

COMMITTEE MEMBER: Never seen them, don't know where to get them.

MS. PARKER: Okay. We'll definitely share -- share those -- I think that'll be a good place to at least some of the discussion.

MR. GRAY: It would be my recommendation. I mean, they -- they will give a lot of information at the end of the day and give you some punching and some direction where each facility in your region might need to go. So I mean, I recommend that everyone take those.

(Several committee members started talking all at once.)

COMMITTEE MEMBER: -- natural referral patterns --

COMMITTEE MEMBER: Yeah.

COMMITTEE MEMBER: -- that's already there.

COMMITTEE MEMBER: Except my -- if it works right, if it's not --

COMMITTEE MEMBER: It'll be a place to go from again.

COMMITTEE MEMBER: Because I think sometimes referrals are made on various reasons. So it might be the best way to score that if it's where you want to take it. Sounds like you rather them not be.

MS. PARKER: When was the last survey done?

MR. EDWARDS: When was the last one done?

MS. PARKER: Yeah.

MR. EDWARDS: 2016.

MS. PARKER: '16. Awesome, thank you.

MR. EDWARDS: The next one is next year. The difficulty is going to be getting a good contact list to send it out to, email-wise. It's designed to go to like a nurse manager of an ER.

It doesn't have to be that person, but that's kind of who it's aimed at. But our -- it's horrible trying to get to the right person at each hospital.

COMMITTEE MEMBER: Does the coalition have that information?

MR. DAY: Well if not, the -- the regional EMS councils have those -- have the nurse manager contacts.

MR. EDWARDS: That's -- I will

double check and see how complete that is. Because I thought that -- I thought that in the past the list happened to be complete. So thank you, that's a --

MR. DAY: Yeah.

MR. EDWARDS: -- good point.

MR. DAY: Okay. So the other thing that I wanted to talk about coming out of the -- the meeting out of Vegas was blood products. And I just talked to Dr. Aboutanos this morning.

We kind of -- we talked about this at our trauma program manager meeting, our last one. And I was very interested to find -- I kind of polled everybody in the -- in the state and found out some very interesting things.

Because we were pushing -- what I'll -- I'll open this up with, we were using whole blood in Iraq a long time ago. A long time ago. So when I came home the first time, I'm like, well, why aren't we

using it here? I go, oh, my God, you can't do that. So it's now 2019. I'll preface this with it was over time -- 20 years ago. Okay. So now we have a meeting. This -- this is Friday -- this week.

The Red Cross told me before our last trauma program managers meeting that we were no -- we were not in any way, shape or form going to be able to use O-negative blood.

Because it was too expensive to use O-negative blood because they could break up and make a lot more money on that blood. So we were no -- we were not going to be able to give females whole blood.

This week, after coming back from the Vegas disaster meeting and the Red Cross speaking at that saying, oh, I don't know who told you that.

All of a sudden, we are now getting whole blood, O-positive and O-negative, and never frozen plasma in Hampton Roads. So I talked to Dr. Aboutanos this morning. He goes, you're getting what? We're not getting that. I said, well, you

get your blood from the same Red Cross as I do. So you need to talk to somebody. So this is -- this is the top 10 transfusion pearls for mass casualty events.

Number one, blood far forward has been proven to save lives. Just so you know, the military has been using walking -- or whole blood and nobody in this room is old enough to remember that -- in World War I.

Nobody in this room is that old. So World War I. Minutes matter when it comes to hemorrhage. Giving blood products early decreases mortality. And if anybody doesn't believe that, they haven't been doing trauma very long.

Minutes matter. So when we talk -- we just changed our -- our master transfusion using shock index from Carilion. Carilion.

And that's just since the begin -- since January 1st we changed our master transfusion trigger. We have increased our master transfusion. We've now -- and we're a Level III trauma center. We

have done 12 master transfusions since January 1st. Our season doesn't even start until summertime, and we've already done 12. With our huge increase in our out -- our outcome data in master transfusion.

Whole blood -- whole blood, over 100 years of proven safety and efficacy from the military. Pre-screened instance -- this is what I'm talking about now.

Here's the other thing we're talk -- that I was telling Kelly earlier is they came out of the -- this meeting in -- at -- the American College of Surgeons meeting in -- in Las Vegas was they need to talk about how we can get blood products earlier in a disaster situation.

Now we had talked -- Kelly, you were a part of this discussion earlier on in this process when we were -- probably last year. If we have a disaster, we're going to talk -- we'll just say this room.

We're all working in a trauma center. We have a disaster -- not an MCI, but a real disaster where we need blood products. We have now used up what we have

in our trauma center. How do we get our blood products re-supplied? Does anybody in this room know that process?

MS. BROWN: This is Kelly from Lynchburg, Centra. And I can tell you that when we deplete both of our hospital's -- because I have two hospitals 3.3 miles apart.

The blood bank's already calling the Red Cross in Roanoke. And what they tell me is it's -- they're sending me more blood.

MR. DAY: They're telling you --

MS. BROWN: It's what they tell me.

MR. DAY: How do you practice that?

COMMITTEE MEMBER: How long does it take?

MS. BROWN: Two hours.

MR. DAY: That's what they tell you.

MS. BROWN: Right. So --

MR. DAY: So in a disaster and your roads are no longer good, how's your two hours?

MS. BROWN: Well -- and that's correct. I don't know that we've ever -- this is what I was told.

MR. DAY: Right.

MS. BROWN: I don't know if we've ever had to test it.

MR. DAY: Correct.

MS. BROWN: Is that fair enough to say? Yeah.

MR. DAY: So the other part of your blood management program is testing your

blood management program every time you do a disaster plan -- disaster drill is to build your blood management program in your disaster plan.

So if you do -- like we're going to be doing another disaster drill with the Oceanic Air Show. What's month are we? May, so it'll be June or July.

We'll do another large scale disaster drill at the Oceana Naval Air Station. They'll be in some kind of a crash. We'll do a very large scale mass casualty drill. We've -- every year.

And we will build in the use of your blood management. So we will practice re-supplying. And they said -- the ACS has just put out you've got to build in to your drill prep how to do that.

Because if you're not doing that, your blood bank is not versed in re-supply. So you're going, well, they'll just pull the paperwork out. If you're amped up in your part of your drill, how do you think they're going to be in a real mass casualty when they're emptying their blood

bank for you. And then they're going, oh, my God. I've got to get more blood. And at what point are they doing that? When the last unit comes off the shelf?

Half way through the -- their supply? Three-quarters of the way through their supply? You'd need to have those conversations with your blood bank.

So the other thing is, is how does the Red Cross re-supply themselves? Because take Hampton Roads. If you've got all these hospitals trying to re-supply blood, how are they going to re-supply themselves to re-supply you?

And Kelly was just saying that what -- what -- well, let me push that. So what the red -- ACS said is you should -- you know how we have Amber Alerts on your highway? It says Amber Alert, Amber Alert.

Well they said, they should have -- the Red Cross should have a pre-set spot that -- how many O-neg -- how many O-pos -- blood types do we have in the room? All of you know that you're O's. They call out a blood -- blood need that they should

all the 'O' -- should already know that you should go to this specific site to give blood.

COMMITTEE MEMBER: A blood alert?

MR. DAY: A blood alert. Instead of an Amber Alert, it's a blood alert.

COMMITTEE MEMBER: But the Red Cross already does some of that targeting as it is in when they're critical on like RH Negative, they're -- they're targeting the donors that already have a relationship with.

MR. DAY: True. But in a large scale --

COMMITTEE MEMBER: Sure.

MR. DAY: -- using the Amber Alert system, put on your phone -- how you get an Amber Alert, on the -- on the highways and that way. But Kelly is saying, which I

didn't know, that they're not -- the Red Cross of Hampton Roads isn't getting their blood from the locals. It's coming from out of the area.

MS. PARKER: So Steve might be able to -- not to put you on the spot back there, Steve. But he might be able to talk a little bit to -- to the central region.

I'm not sure what kind of blood issues that have been going on. And I mean, that may have changed now that Red Cross took over Virginia --

GALLERY MEMBER: Well, things have changed a little bit since Red Cross. But back last year, they did a little bit of a presentation at one of our coalition meetings where they showed that the actual influx of blood in the Richmond Metro area was, which I assume they're returning, are very low -- less than 20% of those donors back to this region because of the way they're being processed. They actually didn't have a process center right here in

Richmond until Red Cross recently bought out the blood service that was previously here. And now that is ramped back up a little bit better.

But I do not have statistical information on where that's changing at this point. And of course, VCU shared with us the fact that, you know, a couple of the shootings on the Hill at night and so forth in the City of Richmond would wipe out 50% of their blood bank --

COMMITTEE MEMBER: Yep.

COMMITTEE MEMBER: -- you know, and so forth, and transition put them in a crisis mode. As far as the re-supply, I would like to say that probably since those systems do that on a regular basis, they are our go-to as far as probably a lot of that statistical information and detail on how they do re-supply. Regardless of whether you do it in an exercise or not, they are a go-to. And I think you can go and put in those exercises much like they share whether

or not you include a PIO in your exercise or whatever. If you don't put a particular discipline in your exercise you haven't really exercised it to see how well it's going to flow.

So to your point, I think it's a great concept to do that. And I do think we have the medical expertise in the region to do it. At least in central.

COMMITTEE MEMBER: That's interesting to hear. You know, I take a step further and we developed a crisis -- crisis standard for blood -- blood availability. And not only do we have triggers in there for low levels.

And then notifying the physicians that are routinely ordering MTP's and doing procedures, so we can potentially stop those elective procedures from happening if we can.

And -- and then we -- in order to determine, if we had to, who gets -- who gets what blood products? There's a list of criteria. It's not an algorithm.

Algorithms don't work --

COMMITTEE MEMBER: Right.

COMMITTEE MEMBER: -- considerations do. But to -- to your point about how -- that you re-order through the Red Cross. Is there any other health system that's fortunate enough to have your own in-house --

MR. DAY: I know that Inova does.

COMMITTEE MEMBER: Yeah. And so what happens when one of our hospitals goes out, as we go back to the mothership in Sterling and they can ship it.

And it's typically fast enough to get anywhere it needs to be. We've never ran out -- yet. And now -- and now -- and then until this afternoon.

But if we had to re-order, and we have had to re-order, we pay a premium to other health systems and other private groups and non-NGO's to -- to buy that blood

and get it shipped directly to our facilities. And that is also an interesting cascading and -- how does blood move? That -- I think that would be an interesting study as well.

And I mean, there's some pretty particular blood types. I'm not a clinician, but it can get sticky real fast for those really low frequency blood types. Yes, sir.

MR. SCHWALENBERG: Tom Schwalenberg, Tidewater EMS Council. So from a pre-hospital perspective, we're looking at this as well. Should we carry blood?

How do we carry blood, that kind of stuff. When you look at some of the agencies around the country that are doing this, the ones that I've seen be most successful are those agencies that basically re-supply themselves. And what I mean by that is they build up their program so that they have donors within their systems. And they donate on a regular basis. And -- and

that was sort of a -- an agreement between the blood bank that was supplying the blood is that if you can provide us 'x' amount of blood of these types over 'x' amount of time, then we will supply your units.

And so they -- they kind of feed the machine themselves. Now obviously you're talking large agencies that have the, you know, the personnel to do that.

But I don't know, just a -- you know, just spit-balling here, I don't know from a hospital perspective is -- and you may already be doing it, I'm just not aware.

But would that be the way to work with your blood bank partners to say, with -- with -- from our employees, we'll give 'x' amount of blood over 'x' amount of time anywhere for you to re-supply for MTP. Just -- I'm just throwing it out there as a consideration.

MR. DAY: That's an interesting thought. I know -- like I said, Inova has -- their own internally. They do an

internal -- they have their own internal process. So they don't -- they're not -- they're not at the Red Cross's wait like a lot of the other -- like Richmond, like VCU and Sentara is.

MR. GRAY: I'm not sure exactly how they -- functionality pieces of it, but my region I butt right up against Tennessee. But -- so the big health system that's in Tennessee and Virginia, they have like a -- a Marsh blood bank is what they call it. So -- and they have a system sort of that nature is how they do it.

MR. SCHWALENBERG: Okay.

MR. GRAY: And I'm not 100% familiar with how that works, but I know they have one.

MR. DAY: So I guess what I -- what -- what to take out of this is, if you -- to back to is to make sure that people are looking at the blood component in their

exercises so that they know that this part of this -- this is a big part of your disaster plan. And that it is being exercised.

Not just in the ED, not just in the OR, the ICU, but in the actual blood bank. And that it's after action, so that your blood bank can return out and you can get some lessons learned on, hey, my blood bank actually pulled the paperwork out, has the numbers to call.

Knows how to fill the paperwork out. And could tell me what point in this exercise they were pulling the trigger on a re-supply, and knows how to do it.

So just wanted to pass that on as a state to state level so that you can go back to your areas and -- and your hospitals and -- and talk about that.

Okay, what? All right, does anybody have at this point -- on -- opened up. Did anybody have anything burning on their mind? Sir?

COMMITTEE MEMBER: Everything is burning in my mind.

MR. DAY: That's good. That's good.

COMMITTEE MEMBER: So I like the way you think.

COMMITTEE MEMBER: Chesterfield County is going to have a mass casualty disaster drill at one of their schools later this summer.

If I can -- my -- I'll find out more details, but they're going to take an old school that they're decommissioning and play it up.

MR. DAY: Good.

COMMITTEE MEMBER: And actually destroy the building.

COMMITTEE MEMBER: Thursday, July 25th.

COMMITTEE MEMBER: That's it, yeah. It's old Crestview High -- is it old Crestview?

COMMITTEE MEMBER: Crestwood.

COMMITTEE MEMBER: Crestwood?

COMMITTEE MEMBER: Yeah. See, it's the one up in the northern part of the county. I don't have the --

COMMITTEE MEMBER: Crestwood.

COMMITTEE MEMBER: I think it's Crestwood Elementary.

COMMITTEE MEMBER: Mm-hmm, off of Jahnke.

COMMITTEE MEMBER: Yeah, it's the one that they're actually decommissioning.

COMMITTEE MEMBER: And the idea is that -- it's going to be -- any part of it.

So it might be something that, if nothing else, just to watch. See if it's something to learn from.

MR. DAY: Good, that sounds good. The more -- I think the more we do that, the better off we're going to all be. I mean --

COMMITTEE MEMBER: Brings up a question. What's out there that's already been done that needs starting again. You know, after action reports and other -- not just limited to the state, but other places.

MR. DAY: I can have access to that. Better if I do it.

MS. PARKER: Yes. It'll take me a little bit of research, but we do have some databases I can look at to see what's been shared in terms of after action reports or exercises and -- of the like.

COMMITTEE MEMBER: Are you supposed to go on the -- the agency web site?

COMMITTEE MEMBER: Are you talking about LOS?

COMMITTEE MEMBER: No, the after action report.

COMMITTEE MEMBER: Yeah, on LOS. Pretty much nobody does that any more.

MS. PARKER: There's a -- there's a resource that we -- we use. It's through HHS and ASPR. It's called TRACIE --

MR. DAY: Yeah.

MS. PARKER: ASPR TRACIE web site. And it's -- it's managed by the feds. But it's kind of a -- a one-stop shop resource for all things health care, disaster, emergency preparedness and coalition emergency preparedness.

From response plans from exercises from White Papers. Everything but -- anything that is posted on there has gone through a decently vigorous peer-reviewed

process from subject matter experts across the country. So it's not -- not anything just gets posted. Everything is -- is reviewed prior to being posted on their web site.

And it's a -- it's -- you could get a log-in. I think they -- I think they grant it to anybody. I don't know if there's any restrictions on that.

But that -- that's where I would start to -- to look for some of this -- this type of information. That's all I have.

COMMITTEE MEMBER: That's all I got.

MS. PARKER: Anyone else? Comments, questions?

MR. DAY: All right. Thank you, guys. That was a pretty robust talk today.

(The Emergency Preparedness and Response Committee meeting concluded.)

CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, do hereby certify that I transcribed the foregoing EMERGENCY PREPAREDNESS AND RESPONSE COMMITTEE MEETING heard on May 3rd, 2019, from digital media, and that the foregoing is a full and complete transcript of the said committee meeting to the best of my ability.

Given under my hand this 5th day of July, 2019.

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2020.